June 26, 2003

Re: Medical Dispute Resolution
MDR #: M2-03-1177-01
IRO Certificate No.: 5055

In accordance with the requirement for TWCC to randomly assign cases to IROs, TWCC assigned your case to ___ for an independent review. ___ has performed an independent review of the medical records to determine medical necessity. In performing this review, ___ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

The independent review was performed by a matched peer with the treating health care provider. Your case was reviewed by a physician who is Board Certified in Pain Management.

Clinical History:
This female claimant injured her right foot in a work-related accident on ___. She has been evaluated and treated by multiple physicians, and has undergone physical therapy. The patient has had a prolonged and protracted period post-injury, during which time the therapeutic interventions have included standard physical therapy, stretching exercises, a home program, CAM walking boot, and other physical interventions. These measures have been relatively unsuccessful in relief of pain.

The records provided for review indicate that the patient has been unsuccessful in returning to gainful employment since her injury.

Disputed Services:
Chronic pain management program X 20 days.

Decision:
The reviewer agrees with the determination of the insurance carrier. The reviewer is of the opinion that a pain management program is not medically necessary in this case.

Rationale for Decision:
Medical documentation does not provide a reliable or objective basis for diagnosis of complex regional pain syndrome (CRPS), as the patient has not received a lumbar sympathetic block to evaluate pain and blood flow changes. Side-to-side differential temperatures do not appear to be significantly different to touch, and the bone scan of 09/27/02 indicates normal flow and pool to both extremities.

I am the Secretary and General Counsel of ___ and I certify that the reviewing physician in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this care for determination prior to referral to the Independent Review Organization.

We are simultaneously forwarding copies of this report to the payor and the Texas Workers' Compensation Commission. This decision by ___ is deemed to be a Commission decision and order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of this decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings **within ten (10) days** of your receipt of this decision (28 Tex. Admin. Code 142.5©).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings **within twenty (20) days** of your receipt of this decision (28 Tex. Admin. Code 148.3).

This Decision is deemed received by you **five (5) days** after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5 (d)). A request for a hearing should be sent to:

Chief Clerk of Proceedings
Texas Workers' Compensation Commission
P.O. Box 40669
Austin, TX 78704-0012

A copy of this decision should be attached to the request. The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute.

I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on June 26, 2003.

Sincerely,